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Medica Group Advantage Solution℠ (PFFS)



Summary of Benefits

H2409-801

January 1 - December 31, 2010

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Section I :

Introduction to the Summary of Benefits for Medica Group Advantage Solution℠ (PFFS)
January 1 - December 31, 2010

Thank you for your interest in Medica Group Advantage Solution℠ (PFFS). Our plan is offered by Medica Health Plans, a Medicare Advantage Private-Fee-For-Service organization. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Medica Group Advantage Solution and ask for the "Evidence of Coverage".

You have choices in your health care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Medica Group Advantage Solution.

You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program. Please contact your Group Administrator or Medica to discuss what your options may be.

You may be able to join or leave a plan only at certain times. Please call Medica Group Advantage Solution at the number listed at the end of this introduction, your benefits department or 1-800-MEDICARE 1-800-633-4227 for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How can I compare my options?

You can compare Medica Group Advantage Solution and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where is Medica Group Advantage Solution available?

The Medica Group Advantage Solution service area is all 50 U.S. states and territories provided the Employer Group meets certain eligibity requirements.

Who is eligible to join Medica Group Advantage Solution?

You can join Medica Group Advantage Solution if:

- You meet the eligibility requirements established by the group plan sponsor.
- You are enrolled in Medicare Part A and Part B.
- You continue to pay your Medicare Part B premium.
- You live in the United States.
- You do not have End Stage Renal Disease (ESRD) unless:
  1) You are already enrolled in a Medica plan as a non-Medicare member and you developed ESRD while a Medica member; or
  2) You have had a successful kidney transplant and no longer require dialysis; or
  3) You are medically determined to first have ESRD **after** the date you elect Medica Group Advantage Solution, but **before** the effective date of coverage under the plan. (The date you select Medica Group Advantage Solution is the date the enrollment form is signed, the receipt date stamp if no date is on the form, or the date election is made by alternate means provided by CMS.)

Can I choose my doctors?

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. As a member of Medica Group Advantage

Solution, you can use any Medicare doctor, specialist, or hospital that accepts Medicare payment and accects the terms, conditions and payment rate of the Medica Health Plans plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. Medica Health Plans has the right to determine if the service or treatment ordered by your health care provider is covered under the Plan. If your doctor or hospital does not agree to accept our payment terms and conditions, or otherwise agree to treat you, you will not be able to receive covered services from them under this plan. Providers can find the plan's terms and conditions on our website at www.medica.com.

Does my plan cover Medicare Part B or Part D drugs?

Medica Group Advantage Solution does cover Medicare Part B prescription drugs. It also covers Medicare Part D prescription drugs.

Where can I get my prescriptions if I join this plan?

Medica Group Advantage Solution has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at https:/www.medica.com/C12/DrugFormularyPartD/default.aspx. Our customer service number is listed at the end of this introduction.

What is a prescription drug formulary?

Medica Group Advantage Solution uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at https:/www.medica.com/C12/DrugFormularyPartD/default.aspx.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How can I get extra help with my prescription drug plan costs?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

What are my protections in this plan?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Medica Group Advantage Solution, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be

covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service.

If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. For **Minnesota:** Stratis Health, 952-854-3306 or 1-800-444-3423 (toll free). TTY users should dial the Minnesota Relay number at 1-800-627-3529; for **North Dakota:** North Dakota Health Care Review, 1-701-852-4231; for **South Dakota:** 1-605-336-3505; for **Wisconsin:** 1-800-362-2320.

What are my protections Under the Medica Part D plan?

As a member of Medica Group Advantage Solution, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request.

If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. For **Minnesota:** Stratis Health, 952-854-3306 or 1-800-444-3423 (toll free). TTY users should dial the Minnesota Relay number at 1-800-627-3529; for **North Dakota:** North Dakota Health Care Review, 1-701-852-4231; for **South Dakota:** 1-605-336-3505; for **Wisconsin:** 1-800-362-2320.

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Medica Group Advantage Solution for more details.

What types of drugs may be covered under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Medica Group Advantage Solution for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

Plan Ratings

The Medicare Program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-800-575-2330 to obtain a copy of the plan ratings for this plan. TTY users please call the National Relay Center at 1-800-855-2880 and ask for 1-800-575-2330.

Please call Medica Health Plans for more information about Medica Group Advantage Solution. Visit us at www.medica.com or, call us:

Customer Service Hours:
8 a.m. to 8 p.m., CST, seven days a week. Please note that access to a representative is limited on the weekends/holidays during certain times of the year.

For questions related to Medica Group Advantage Solution and Medicare Part D Prescription Drug Program:
Current members should call **952-992-2330** or **1-800-575-2330** (TTY: please call the National Relay Center at **1-800-855-2880** and ask for **1-800-575-2330**).
Prospective members should call **952-992-2330** or **1-800-575-2330** (TTY: please call the National Relay Center at **1-800-855-2880** and ask for **1-800-575-2330**).

For more information about Medicare:
Call 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week. Or, visit **www.medicare.gov** on the Web.

If you have special needs, this document may be available in other formats.

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Section II:

Summary of Benefits for Medica Group Advantage Solution[SM] (PFFS) for Contract Year 2010
If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
IMPORTANT INFORMATION	
1. Premium and Other Important Information	• In 2010 the monthly Part B Premium is $110.50. • In 2010 the yearly Part B deductible amount is $155. (1) (2) Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (over $85,000 for singles, $170,000 for married couples.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
2. Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	• You may go to any doctor, specialist or hospital that accepts Medicare.
INPATIENT CARE	
3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	• In 2010 the amounts for each benefit period (3) are: - Days 1 - 60: $1,100 deductible - Days 61 - 90: $275 per day. - Days 91 - 150: $550 per lifetime reserve day. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

Medica Group Advantage Solution #79017

General

- You continue to pay the monthly Medicare Part B premium.
- Your monthly premium is dependent on the Medica Group Advantage Solution benefits and plan options that your employer group chose to offer to you.
- You may be responsible for a portion of the monthly premium. Your employer group sponsor will determine how much of the monthly premium is your responsibility.
- $200 deductible each calendar year.
- $3,000 out-of-pocket limit every year for all covered plan services, including the deductible.
- All plan services, including the deductibles, included under the out-of-pocket limit All prescription drugs and pharmacy services are included under the out-of-pocket limit.
- Medicare excluded medications are not included in the accumulation of maximum out-of-pocket.

- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.
- A separate doctor office visit copayment may apply for certain services.

- Deductible applies.
- $100 copay
- No limit to the number of days covered by the plan each benefit period.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
INPATIENT CARE (CONTINUED)	
4. Inpatient Mental Health Care	• Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). (3) (4) • 190 day lifetime limit in a Psychiatric Hospital. (4)
5. Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	• In 2010 the amounts for each benefit period (3) after at least a 3-day covered hospital stay are: - Days 1 - 20: $0 per day - Days 21 - 100: $137.50 per day. • There is a limit of 100 days for each benefit period. (3)
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	• $0 copay.
7. Hospice	• You pay part of the cost for outpatient drugs and inpatient respite care. • You must get care from a Medicare-certified hospice.
OUTPATIENT CARE	
8. Doctor Office Visits	• 20% coinsurance. (1) (2)

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

- Deductible applies.
- $100 copay
- Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible applies.
- $0 copay per stay for SNF services.
- Plan covers up to 100 days each benefit period.

- Deductible applies.
- $0 copay for Medicare-covered home health visits.

General
- You must get care from a Medicare-certified hospice.

General
- See #33 "Physical Exams," for more information.
- Deductible applies.
- $20 copay for each primary care doctor visit for Medicare-covered benefits.
- $20 copay for each in-area, network urgent care Medicare-covered visit.
- $20 copay for each specialist doctor visit for Medicare-covered benefits.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
OUTPATIENT CARE (CONTINUED)	
9. Chiropractic Services	• Routine care not covered. • 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. (1) (2)
10. Podiatry Services	• Routine care not covered. • 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. (1) (2)
11. Outpatient Mental Health Care	• 45% coinsurance for most outpatient mental health services. (1) (2)
12. Outpatient Substance Abuse Care	• 20% coinsurance. (1) (2)
13. Outpatient Services/Surgery	• 20% coinsurance for the doctor. (1) (2) • 20% of outpatient facility charges. (1) (2)

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

- Deductible applies.
- $20 copay for each Medicare-covered chiropractic visits.
- Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible applies.
- $20 copay for each Medicare-covered podiatry visit.
- Medicare-covered podiatry benefits are for medically-necessary foot care.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible applies.
- $20 copay for each Medicare-covered individual or group therapy visit.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible applies.
- $20 copay for each Medicare-covered individual or group therapy visit.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible applies.
- $50 copay for each Medicare-covered ambulatory surgical center visit.
- $50 copay for each Medicare-covered outpatient hospital facility visit.
- More than one copayment may apply per visit.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
OUTPATIENT CARE (CONTINUED)	
14. Ambulance Services (medically necessary ambulance services)	• 20% coinsurance. (1) (2)
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	• 20% coinsurance for the doctor. (1) (2) • 20% of facility charge, or a set copay per emergency room visit. (1) (2) • You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. • NOT covered outside the U.S. except under limited circumstances.
16. Urgently Needed Care (This is NOT emergency care.)	• 20% coinsurance, or a set copay. (1) (2) • NOT covered outside the U.S. except under limited circumstances.
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	• 20% coinsurance. (1) (2)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES	
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	• 20% coinsurance. (1) (2)
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	• 20% coinsurance. (1) (2)

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

- Deductible applies.
- $25 copay for Medicare-covered ambulance benefits.

General
- Deductible applies.
- $50 copay for Medicare-covered emergency room visits.
- Worldwide coverage.
- If you are admitted to the hospital within 24-hours for the same condition, you pay $0 for the emergency room visit.

General
- Deductible applies.
- $50 copay for Medicare-covered urgent-care visits.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible applies.
- $20 copay for Medicare-covered Occupational Therapy visits.
- $20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible applies.
- 20% of the cost for Medicare-covered items.

- Deductible applies.
- 20% of the cost for Medicare-covered items.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
OUTPATIENT MEDICAL SERVICES AND SUPPLIES (CONTINUED)	
20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	• 20% coinsurance. (1) (2) • Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.
PREVENTIVE SERVICES	
21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	• 20% coinsurance for diagnostic tests and x-rays. (1) (2) • $0 copay for Medicare-covered lab services. (1) (2) • Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.
22. Bone Mass Measurement (for people with Medicare who are at risk)	• 20% coinsurance. (1) (2) • Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

- Deductible applies.
- 20% of the cost for Diabetes self-monitoring training.
- 20% of the cost for Nutrition Therapy for Diabetes.
- 20% of the cost for each Medicare Part B-covered Diabetes supply item.

- Deductible applies.
- $0 copay for Medicare-covered:
  - lab services
  - diagnostic procedures and tests
  - X-rays
  - diagnostic radiology services (not including X-rays)
  - therapeutic radiology services
- Separate Office Visit cost sharing of $20 may apply.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible does not apply.
- $0 copay for Medicare-covered bone mass measurement.
- Separate Office Visit cost sharing of $20 copay and deductible may apply.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
PREVENTIVE SERVICES (CONTINUED)	
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	• 20% coinsurance. (1) (2) • Covered when you are high risk or when you are age 50 and older.
24. Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	• $0 copay for Flu and Pneumonia vaccines. • 20% coinsurance for Hepatitis B vaccine. (1) (2) • You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.
25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)	• 20% coinsurance. (2) • No referral needed. • Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.
26. Pap Smears and Pelvic Exams (for women with Medicare)	• $0 copay for Pap smears. (2) • Covered once every 2 years. Covered once a year for women with Medicare at high risk. (2) • 20% coinsurance for Pelvic Exams. (2)
27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	• 20% coinsurance for the digital rectal exam. (2) • $0 for the PSA test. (2) • 20% coinsurance for other related services. (2) • Covered once a year for all men with Medicare over age 50.

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

- Deductible does not apply.
- $0 copay for Medicare-covered colorectal screenings.
- Separate Office Visit cost sharing of $20 copay and deductible may apply.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible does not apply.
- $0 copay for Flu and Pneumonia vaccines.
- $0 copay for Hepatitis B vaccine.
- No referral needed for Flu and pneumonia vaccines.
- No referral needed for other immunizations.
- Separate Office Visit cost sharing of $20 copay and deductible may apply.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible applies.
- $0 copay for Medicare-covered screening mammograms.
- Separate Office Visit cost sharing of $20 copay and deductible may apply.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible does not apply.
- $0 copay for Medicare-covered pap smears and pelvic exams.
- Separate Office Visit cost sharing of $20 copay and deductible may apply.
  - up to 1 additional pap smear and pelvic exam every year.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible does not apply.
- $0 copay for Medicare-covered prostate cancer screening.
- Separate Office Visit cost sharing of $20 copay and deductible may apply.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
PREVENTIVE SERVICES (CONTINUED)	
28. End-Stage Renal Disease	• 20% coinsurance for renal dialysis. (1) (2) • 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease. (1) (2) • Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.
ADDITIONAL BENEFITS (What Original Medicare Does Not Cover)	
29. Prescription Drugs	• Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

General

- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.
- Deductible applies.
- 0% of the cost for renal dialysis.
- 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.

Drugs covered under Medicare Part B

General

- Deductible applies.
- 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.

Drugs covered under Medicare Part D

General

- This plan has a separate deductible for prescription drugs.
- This plan uses an open formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary changes that limit our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you upon request or you can see our complete formulary on our Web site at www.medica.com.
- Different out-of-pocket costs may apply for people who have limited incomes, live in long term care facilities, or have access to Indian/Tribal/Urban (Indian Health Service). Contact plan for details.
- Coverage will not be provided for prescription drugs that are not on the Medica open drug formulary.
- The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-charing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).
- Total yearly drug costs are the total drug costs paid by both you and the plan.
- Covered Part D drugs are available at out-of-network pharmacies in special circumstances, including illness while traveling outside of the plan's service area where there is no network pharmacy.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
ADDITIONAL BENEFITS (What Original Medicare Does Not Cover) (CONTINUED)	
Deductible	
Initial Coverage	

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

- Prescription drugs must be received from network retail pharmacies or designated mail order pharmacy for your benefits to apply.
- For prescription drugs and pharmacy services, you have a combined annual out-of-pocket maximum of $3000. Once you have paid $3000 in Medicare Part D eligible copayments and coinsurances, your prescription drugs will be covered at 100% for the remainder of the calendar year.
- These presecription drug out-of-pocket expenses also apply toward the annual out-of-pocket maximum for all other plan services under the Medica Group Prime Solution plan.
- The plan may require you to first try one or two drugs to treat your medical condition before they will cover another drug for that condition.
- Certain prescription drugs may have maximum quantity limits.
- Your provider may need to get prior authorization from Medica for certain prescription drugs.
- You may need to go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in the network. These drugs are listed on the plans' Web site, formulary, and printed material.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the acutal cost, not the higher cost-sharing amount.
- Certain Medicare excluded prescription drugs are included in your benefits. (See insert in your formulary for details).
- Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy.
- You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. You may likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Medica Group Prime Solution.
- Please contact Medica for details.

There is a $200 prescription drug deductible in addition to the deductible for other medical expenses under your Medica Group Prime Solution plan. Your deductible is the amount that you must pay for covered drugs each calendar year before this plan begins paying for part of your drug costs.

You pay the following for covered prescription drugs until you reach the maximum out of pocket of $3000 for all covered services, including prescription drugs.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
ADDITIONAL BENEFITS (What Original Medicare Does Not Cover) (CONTINUED)	
Retail Pharmacy	
Mail Order	
30. Dental Services	• Preventive dental services (such as cleaning) not covered.

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

Formulary Generic
- $15 copay for a one-month (31-day) supply of drugs in Tier 1
- $45 copay for a three-month (93-day) supply of drugs in Tier 1, at certain pharmacies

Formulary Preferred Brand
- $30 copay for a one-month (31-day) supply of drugs in Tier 2
- $90 copay for a three-month (93-day) supply of drugs in Tier 2, at certain pharmacies

Formulary Non-Preferred Brand
- $60 copay for a one-month (31-day) supply of drugs in Tier 3
- $180 copay for a three-month (93-day) supply of drugs in Tier3, at certain pharmacies

Formulary Specialty
- $60 copay for a one-month (31-day) supply of drugs in Tier 4
- $180 copay for a three-month (93-day) supply of drugs in Tier 4 at certain pharmacies

Long Term Care Pharmacy

Formulary Generic
- $15 copay for a one-month (31-day) supply of drugs in Tier 1

Formulary Preferred Brand
- $30 copay for a one-month (31-day) supply of drugs in Tier 2

Formulary Non-Preferred Brand
- $60 copay for a one-month (31-day) supply of drugs in Tier 3

Formulary Specialty
- $60 copay for a one-month (31-day) supply of drugs in Tier 4

If the actual cost of the drug is less than the copay, then you will pay the lesser amount.

Formulary Generic
- $30 copay for a one-month (31-day) supply of drugs in Tier 1

Formulary Preferred Brand
- $60 copay for a one-month (31-day) supply of drugs in Tier 2

Formulary Non-Preferred Brand
- $120 copay for a one-month (31-day) supply of drugs in Tier 3

Formulary Specialty
- $120 copay for a one-month (31-day) supply of drugs in Tier 4

- In general, preventive dental benefits (such as cleaning) are not covered.
- Deductible applies.
- 20% of the cost for Medicare-covered dental benefits.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or cost, please contact Medica Health Plans for details.

Benefit	Original Medicare
ADDITIONAL BENEFITS (What Original Medicare Does Not Cover) (CONTINUED)	
31. Hearing Services	• Routine hearing exams and hearing aids not covered. • 20% coinsurance for diagnostic hearing exams. (1) (2)
32. Vision Services	• 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. (1) (2) • Routine eye exams and glasses not covered. • Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. (1) (2) • Annual glaucoma screenings covered for people at risk. (1) (2)
33. Physical Exams	• 20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. (1) (2) • When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.
34. Health/Wellness Education	• Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.
35. Transportation (Routine)	• Not covered.
36. Acupuncture	• Not covered.

(1) Each year, you pay a total of one $155.00 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

- Deductible applies.
- $20 copay for Medicare-covered diagnostic hearing exams.
- Deductible does not apply.
- $0 copay for up to 1 routine hearing test(s) every year.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible applies.
- 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.
- $20 copay for diagnosis and treatment for diseases and conditions of the eye.
- Deductible does not apply.
- $0 copay for 1 routine eye exam every year.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

- Deductible does not apply.
- $0 copay for routine exams.
- Limited to 1 exam every year.
- You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

The plan covers the following health/wellness education benefits:

- Written health education materials, including Newsletters
- Additional Smoking Cessation
- Health Club Membership/Fitness Classes
- Nursing Hotline
- Deductible applies.
- $20 copay may apply for each Medicare-covered smoking cessation counseling session.

- This plan does not cover routine transportation.

- This plan does not cover Acupuncture.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

Section III:

Medica Group Advantage Solution℠ - Count on Medica's Experience

Medica is a Minnesota-based company with over 34 years of not-for-profit health care experience. We currently serve over 1.5 million members, including over 87,400 Medicare members in offered in Minnesota, North Dakota, South Dakota, Wisconsin and throughout the United States to Medicare-eligible individuals through a former employer. The Medica Group Advantage Solution plan is designed to meet the needs of Medicare-eligible individuals who choose to maintain their current Medicare benefits, yet want additional coverage for Medicare deductibles, coinsurance and other out-of-pocket costs. Medica Group Advantage Solution is a Medicare Advantage (MA) Private Fee-for-Service plan. This means that you may see any Medicare-approved medical provider that accepts Medica's payment for the services you receive. You are not restricted to a network or service area.

Medica continues to inspire health care improvement and innovation with the following:

- Exceptional member support and service
- Freedom of provider choice
- A quality-first, member-centered focus
- Easy access to care and wellness programs

Medica's Center for Healthy Aging

We believe that healthy living at every age is important. With that in mind, our Center for Healthy Aging (CHA) provides a comprehensive, unique health care resource dedicated to supporting the needs of our region's Medicare beneficiaries. We offer coverage, products, programs and services for Medicare-eligible retirees and their Medicare-eligible spouses qualifying for retiree coverage through their former employer in both the public and private sectors.

Member Services Support

The CHA Member Services Staff is dedicated and sensitive to the needs of seniors and those of any age living with a disability. They make the transition from work to retirement seamless for retirees while implementing our Medica Group Medicare Solutions plans and continue to build member satisfaction as they provide ongoing information and support. You may contact them from 8 a.m. to 8 p.m., seven days a week. Please note that access to a representative is limited evenings and weekends during certain times of the year.

Health Management Resources

- **Focus on Health™ Newsletter** is published quarterly by Medica for its Medicare health plan members. The health and wellness information is targeted to senior needs and interests and comes from a wide range of medical experts. Current and past versions are available on our website as a permanent health care resource.
- **Medica Disease Management Programs** are clinical programs designed to provide education and resources that help support the members' ability to manage chronic conditions. The goal is to improve health, reduce complications through early intervention and monitoring, and to improve satisfaction with health care services.
- **Medica Tobacco Cessation Program** is an online resource available to support members who are thinking about quitting tobacco or have already quit. In addition to the free access to online quit tools, this program includes periodic phone calls, support from other tobacco users who are trying to quit, and information about medications that may make the quitting process easier.

SilverSneakers Fitness Program

Medica understands the value of staying healthy and active, and that is why we offer the Silver-Sneakers Fitness Program to Medica Advantage Solution members. The program allows participants to take advantage of a basic membership at participating fitness centers and use available amenities such as steam and sauna rooms, aqua exercise classes, exercise equipment, and more. But the centerpiece of this program is a series of exercise, flexibility and strengthening

classes that are especially designed to benefit seniors, regardless of current fitness level. You may also use your SilverSneakers membership when you travel within the U.S.; there are participating facilities throughout the country.

Medica Rx Savings Program

If you have not enrolled in Medicare Part D, as a Medica Advantage Solution member you are still eligible for overall savings—sometimes up to15%—on your prescription drug purchases. When you buy your medicine at retail price from one of Medica's contracted pharmacies you receive a discount on the cost for drugs listed on Medica's extensive Prescription Drug Formulary list. Savings may vary based upon the drug and location of its purchase. Call the Center for Healthy Aging for details.

Medica CallLink Nurse Line

Medica CallLink is an easy-to-use phone service staffed by registered nurses 24 hours a day. With one call, the nurses answer your questions, provide valuable health information, discuss treatment options that may be appropriate during a health episode, and provide guidance about receiving appropriate care for your situation. They also have a large audio reference library if you wish detailed information about specific medical topics.
The Medica CallLink number is 1-866-715-0915.

Notes

Notes

For more information on Medica Medicare Solutions® plans, call **952-992-2330** or **1-800-575-2330**. TTY users may call the National Relay Center at **1-800-855-2880** and ask for **1-800-575-2330**.

Hours of operation:
8 a.m. to 8 p.m., CST, seven days a week. Please note that access to a representative is limited on the weekends/holidays during certain times of the year.

Visit us on the Web at **www.medica.com**

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